MaineCare Services
An Office of the
Department of Health and Human Services
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
MaineCare Services
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TO: Interested Parties

FROM: Anthony Marple, Director, Office of MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Chapter II and III, Section 90, Physician Services

DATE: May 20, 2008

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapters II and III, Section 90. The Office of MaineCare Services is proposing changes to the MaineCare Benefits Manual, Chapters II and III, Section 90, Physician Services.

The Department proposes an increase to the MaineCare reimbursement rate for physician services from fifty-three percent (53%) to sixty-one and seven tenths percent (61.7%) as of July 1, 2008.

In addition to these changes, the Department is proposing to add coverage of application of fluoride topical varnish by physicians for members under the age of twenty-one (21) who are at high risk for caries. Coverage by physicians will increase access to this service that is already covered when by provided by a dentist. Research shows that provision of this preventative service reduces the need for restorative dental services for children.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, Office of MaineCare Services

RULE TITLE OR SUBJECT: MaineCare Benefits Manual, Chapters II and III, Section 90, Physician Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Office of MaineCare Services is proposing changes to the MaineCare Benefits Manual, Chapters II and III, Section 90, Physician Services. The Department proposes an increase to the MaineCare reimbursement rate for physician services from fifty-three percent (53%) to sixty-one and seven tenths percent (61.7%) as of July 1, 2008. In addition to these changes, the Department is proposing to add application of fluoride topical varnish by physicians for members under the age of twenty-one (21) who are at high risk for caries.

SEE http://www.maine.gov/bms/rules/provider_rules_policies.htm **for rules and related rulemaking documents.**

THIS RULE WILL __ WILL NOT _X__ HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 M.R.S.A., § 42, § 3173

PUBLIC HEARING: Wednesday, June 18, 2008 9:00 AM
Location: Department of Heath and Human Services
442 Civic Center Drive
Augusta, Maine 04333-0011

DEADLINE FOR COMMENTS: Comments must be received by midnight June 29, 2008

AGENCY CONTACT PERSON: Patricia Dushuttle
AGENCY NAME: Office of MaineCare Services
ADDRESS: 442 Civic Center Drive
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90.04 **COVERED SERVICES** (cont.)

7. Surgical Team: Allowances for surgery performed under the surgical team concept will be determined on a "By Report" basis.

90.04-26 **Oral and TMJ Surgery Billed with CPT codes**

Providers of oral and temporomandibular joint (TMJ) surgery must also comply with all applicable rules of MBM, Chapter II and III, Section 25, Dental Services, including but not limited to urgent care guidelines and prior authorization. All TMJ surgeries require prior authorization.

90.04-27 **Chiropractic Services**

Chiropractic services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 15, Chiropractic Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-28 **Occupational Therapy Services**

Occupational therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 68, Occupational Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-29 **Physical Therapy Services**

Physical therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 85, Physical Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-30 **Speech Therapy Services**

Speech therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 105, Speech and Hearing Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

90.04-31 **Topical Fluoride Varnish**

Therapeutic application of topical fluoride varnish is covered for members under the age of twenty-one (21) with moderate to high caries risk. For members with high caries risk, MaineCare will cover application two (2) times per calendar year. For members with high caries rates or new restoration within eighteen (18) months, as are documented in the member's record, MaineCare will cover up to three (3) applications per calendar year.

90.05 RESTRICTED SERVICES

90.05-1 Services Covered With Prior Authorization (PA)

Some services and procedures require prior authorization for MaineCare to provide payment. MaineCare lists physician procedures, the amount paid for the service, and whether the procedure requires prior authorization on the Office of MaineCare Services website. When new procedure codes are added to MaineCare reimbursement, MaineCare requires prior authorization. Only some of the categories of procedures requiring prior authorization are detailed in this section; providers are responsible for checking each procedure on the ~~B~~BOMS website to determine whether it is covered and whether it requires prior authorization. Providers should contact the MaineCare Prior Authorization Unit for more information on the prior authorization process.

MaineCare covers the following services only when the Department has granted prior authorization.

A. Breast Reconstruction

MaineCare only covers breast reconstruction with prior authorization, and only covers the procedure after cancer surgery or trauma.

B. Breast Reduction and Mastopexy

Breast reduction and mastopexy require prior authorization and documentation of medical necessity. These procedures are not covered for cosmetic purposes only. Members must meet symptom severity of criteria one or two (1 or 2) below, and all of the criteria three though six (3-6). Members under the age of twenty-one (21) or forty (40) years of age or older must meet additional criteria, as described below.

Documentation required for prior authorization includes all of the following:

1) Member has persistent symptoms in at least two (2) of the anatomical body areas below, affecting daily activities for at least one (1) year:

a) pain in upper back;

b) pain in neck;

c) pain in shoulders;

d) headaches;

90.09 REIMBURSEMENT

90.09-1 Fee Schedule

MaineCare reimburses physicians using a fee schedule known as the MaineCare rate of reimbursement (See Section 90.09-2 A.) The fees or cap associated with service codes are in the MaineCare claims processing database, and are available to any provider who requests a paper or electronic copy. The information is also available on the Office of MaineCare Services website: http://www.maine.gov/bms/provider.htm. Fees are subject to change, although the rate in effect as of the date of service applies for procedures performed on that date.

Providers who use electronic information from the website should note that they are still subject to all applicable MaineCare rules. The MaineCare Program will provide quarterly updates on the website.

Providers must bill using their usual and customary charges and reimbursement will be in accordance with the criteria cited below. Providers must bill medical supplies and therapeutic injections at their cost, using NDC codes where available. Providers should direct any questions to the provider relations specialist assigned to their geographic area of practice.

90.09-2 MaineCare Reimbursement Rate

MaineCare will reimburse the lowest of the following for covered services:

A. The MaineCare rates of reimbursement as found in this Section and posted in the fee schedule on the MaineCare website:

   MaineCare physician fee schedule rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following benchmark:

   For services provided on or after July 1, 2008~~5~~, the fee for service rate is set at sixty-one and seven tenths percent (61.7%) ~~fifty-three percent (53%)~~ of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or

B. The lowest amount allowed by Medicare Part B for Maine area “99” non-facility fee schedule; or

C. The provider’s usual and customary charges; or

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SECTION 90	PHYSICIAN SERVICES	ESTABLISHED 10/15/81 LAST UPDATED 7/20/06

90.01 REIMBURSEMENT

See the rates listed by procedure code on the ~~BMS~~OMS website, at www.maine.gov/bms.

90.02 REIMBURSEMENT CODING

90.02-1 Common Procedure System and Codes

Approximately once a year the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, issue a Healthcare Common Procedure Coding System (HCPCS) transaction list to participating states that includes additions to and deletions from the current schedule of codes. Providers must consult the most recent version of the Current Procedural Terminology (CPT) and HealthCare Financing Common Procedure Coding System (HCPCS) code book(s) for correct billing codes. In those few instances where the CPT and HCPCS code book do not address the needs of the provider, the provider must consult his/her MaineCare Provider Relations Specialist for the appropriate MaineCare-specific code, also called a "local code", if it is not listed in this Section. Providers may also find codes available on the ~~Bureau of Medical~~Office of MaineCare Services website at: www.maine.gov/bms.

A. Level I Codes (CPT)

Providers should use the most recently published edition of the Current Procedural Terminology (CPT), as developed by the American Medical Association. These are five-digit numeric codes and descriptive terms used for reporting medical services and procedures. CPT codes also include two-digit numeric modifiers.

B. Level II Codes (HCPCS)

These are five-digit alphanumeric codes and their descriptions that were developed by CMS for use in defining physician and non-physician services that are not addressed in the CPT coding system.

90.02 **REIMBURSEMENT CODING** (cont.)

(1) Tobacco Cessation Counseling

Code	Tobacco Cessation Counseling	MaineCare Rate
99402	This code may be used alone if the only service provided is tobacco cessation counseling or in addition to appropriate E & M code. Codes that will be paid in addition to 99402 are:	$20
99201-99205	New Patient Office Visit	See Fee Schedule
99211-99215	Established Patient Office Visit	See Fee Schedule
99383-99387	New Patient Preventive Care	See Fee Schedule
99393-99397	Established Patient Preventive Care	See Fee Schedule

C. ~~Level III~~Local and Dental Codes (Local Codes)

The Office of MaineCare ~~Bureau of Medical~~ Services uses the following codes for those services not identified in CPT or HCPCS codes:

(1) Pediatric Dental Anesthesia

Code	Pediatric Dental Anesthesia Description	Rate
ZPD1	Pediatric Dental General Anesthesia (first 30 minutes)	$150.00
ZPD2	Pediatric Dental General Anesthesia (additional 15 minute increment)	$50.00
D1206	Pediatric Topical Fluoride Varnish	$12.00

90.03 **MODIFIERS**

A modifier is a two-character code added as a suffix to the CPT procedure code. A modifier provides the means by which a provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Providers should use modifiers in situations such as:

1. A procedure that has both a professional and technical component;
2. A procedure was performed by more than one physician;
3. A bilateral procedure was performed; or
4. Unusual events occurred.

Providers should use two-character modifiers listed in the most recent CPT guidelines. Providers should note that while CPT guidelines allow for the use of a five digit numeric modifier in addition to the procedure code, MaineCare only accepts and processes two-character modifiers.

As with the procedure codes, there are three types of modifiers: CPT modifiers, which are numerical; HCPCS modifiers, which are alphabetical; and local modifiers, which are also alphabetical. Modifiers can be used interchangeably with all codes; for example, CPT modifiers can be used with HCPCS codes, etc. Some modifiers are meant to affect the fee for a particular service. These are called pricing modifiers. For example, the modifier used to indicate a surgical assist will allow payment of a percentage of the fee paid to the primary surgeon.

Some modifiers do not affect the pricing of a particular code, but they do describe more accurately the service provided. These are called descriptive modifiers. For example, there is a modifier that identifies a service as concurrent care. This modifier more accurately defines the service, but does not affect the level of reimbursement for the service.

Providers must accurately describe a service by using the appropriate code and up to two modifiers. Where this is not possible, providers should use a modifier code “99” to indicate multiple modifiers. The use of modifier “99” will result in manual review of a claim and delayed payment. Therefore, providers should reserve the use of modifier “99” for those situations in which a service can be properly reimbursed only by the use of three or more modifiers.

The following examples illustrate the proper use of modifiers:

Example 1 - Billing for surgical assist at radical mastectomy =

Code		Modifier	
19200	+	80	(fee will be affected)

Example 2 - Surgical assist of cholecystectomy and repair of femoral hernia =

Primary Procedure Code		Modifier Surgical assist
47600	+	80

90.03 **MODIFIERS (cont.)**

Secondary Procedure Code		Modifier Multiple Procedures		Modifier Surgical assist	
49220	+	51	+	80	(fee will be affected)

Example 3 - Arthroplasty, knee, total; radical, left side =

Procedure Code		Modifier left side	
27444	+	LT	(fee will not be affected)

90.03-1 Pricing Modifiers

Modifier	Source	Definition
PC	Local	Technical Component- radiology only (TC also acceptable)
PB	Local	Both Professional & Technical components- radiology only
QZ	Local	Anesthesia by a Registered Nurse- Used when the Registered Nurse provides regional or general anesthesia. Providers should not use this modifier to indicate the use of local anesthesia.